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Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Charles Alan Bennett** **600 Hosking Ave. Unit # 80A** **Bakersfield, CA 93307** **Registered Nurse License No. 538245** Respondent.	Case No. 2010- 332 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about October 30, 1997, the Board of Registered Nursing issued Registered Nurse License Number RN 538245 to Charles Alan Bennett (Respondent.) The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2011, unless renewed.

3. On or about June 28, 2005, the Board of Registered Nursing issued Arizona Registered Nurse License Number RN109600 Respondent. The Arizona Registered Nurse License expired on June 30, 2009.

JURISDICTION

4. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

5. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

6. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

. . . .

"(4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action.

. . . .

7. Section 125.3 of the Code provides, in pertinent part, that the Board/Registrar/Director may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

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CAUSE FOR DISCIPLINE

(Discipline by Arizona State Board of Registered Nursing)

8. Respondent is subject to disciplinary action under section 2761, subdivision (a)(4), on the grounds of unprofessional conduct, in that on or about June 18, 2009, Respondent's Arizona registered nurse license was disciplined pursuant to an Order made by the Arizona State Board of Nursing (Arizona State Board) in a case entitled "*In The Matter of Registered Nurse License No. RN109600 Issued To: Charles Alan Bennett*, Case No. 0808033.

9. The discipline was imposed pursuant to stipulation and based on complaints and/or audits that alleged Respondent committed certain enumerated misconduct including, but not limited to the following:

a. While employed at Maryvale Hospital, Respondent administered intravenous (IV) potassium and Diprovan/propofol without an IV pump, which resulted in patients receiving a medication bolus.

b. While employed at Banner Boswell Medical Center, Respondent diverted narcotics, which were found in a ceiling compartment above the toilet of a restroom.

c. While employed at St. Joseph's Hospital and Medical Center, Respondent frequently asked co-workers to "witness" and sign off for narcotic wastes without visually observing the waste and pulled narcotics for patients who either were not assigned to him or who had already been discharged.

d. While employed by Medical Solutions (Registry), Respondent took home narcotics that were administered to family members.

10. The Arizona State Board further found that Respondent failed to comply with an Interim Board Order, that required him to undergo a substance abuse evaluation that was to be completed within sixty days.

11. As a result of the factual and legal findings of the Arizona State Board, Respondent's Arizona Nurse License was suspended for an indefinite period of time pending completion of a psychological evaluation by a Board approved evaluator and the successful completion of any treatment recommendations resulting from the evaluation. Following completion of the

evaluation and treatment resulting from the evaluation, the Board shall determine the continued status of Respondent's Arizona registered nurse license.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number RN 538245, issued to Charles Alan Bennett.

2. Ordering Charles Alan Bennett to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 1/14/10

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

LA2009603976
accusation.rtf

Janice K. Brewer
Governor

Joey Ridenour
Executive Director

Arizona State Board of Nursing
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AFFIDAVIT OF CUSTODIAN OF RECORDS

STATE OF ARIZONA

COUNTY OF MARICOPA

I, Joey Ridenour, Executive Director for the Arizona State Board of Nursing, County of Maricopa, State of Arizona, do hereby certify that I am the officer having the legal custody for the records hereto attached in the office of the Arizona State Board of Nursing, County of Maricopa, State of Arizona, a public office of said State. The attached copies are true copies of the records on **CHARLES ALAN BENNETT**. Personnel of the Arizona State Board of Nursing prepared the records during the ordinary course of business.

Witness my hand and the seal of the Arizona State Board of Nursing at 4747 N. 7th Street, Suite 200, Phoenix, Arizona 85014-3655 on June 22, 2009.

SEAL

Joey Ridenour RN MN FAAN

Joey Ridenour, R.N., M.N., F.A.A.N.
Executive Director

Arizona State Board of Nursing

Date Printed: 06/22/2009 By: TRINA SMITH, INVESTIGATIONS

NAME CHARLES ALAN BENNETT DOB: 7/2/65

GENDER: M **ETHNICITY:** White - Not of Hispanic Origin

PLACE OF BIRTH **CITY:** CHULA VISTA **STATE:** CA

HOME ADDRESS

12622 W Missouri Ct
Litchfield Park AZ 85340
County: Maricopa
Country: UNITED STATES

HOME PHONE: N/A **PAGER:** N/A **CELL PHONE:** N/A
BUSINESS PHONE: N/A **FAX:** N/A
E-MAIL: az.rnalan@yahoo.com

OTHER NAMES

NAMES USED	REASON	NAMES USED	REASON
<NONE>			

AZ LICENSE/CERTIFICATION INFORMATION:

License/Certificate Number: RN109600 **License Type:** REGISTERED NURSE
Original Date: 02/07/2000
Expiration/Next Renewal Date: 06/30/2009
Last Issued Date: 06/28/2005

Original State of Licensure/Certification:

AZ LICENSE STATUS HISTORY

STATUS	FROM	TO	LAST MODIFIED BY:
Pending Verification from original state of licens	12/06/1999	12/13/1999	DONNA FRYE
Pending FBI Prints	12/06/1999	02/04/2000	bn008732
Temporary	12/06/1999	02/07/2000	bn008732
Application Deficiency Notice Sent	12/06/1999	02/04/2000	bn008732
Pending Board Review	12/06/1999	12/06/1999	gmaxwell
Active: Good Standing	02/07/2000	03/26/2009	TRINA SMITH
Multi State Privileges	07/01/2002	03/26/2009	TRINA SMITH
Complaint/Self Report	08/05/2008	03/26/2009	TRINA SMITH
Under Investigation	03/26/2009	06/22/2009	V. ANN SCHETTLER
Multi State Privileges	03/27/2009	04/30/2009	TRINA SMITH
Multi State Privileges	04/30/2009	06/22/2009	V. ANN SCHETTLER
Valid in Arizona Only	04/30/2009	04/30/2009	TRINA SMITH
Suspended	06/18/2009		V. ANN SCHETTLER

SCHOOL INFORMATION

NAME	LOCATION	NCLEX CODE	DEGREE OBTAINED	GRADUATION DATE
SHASTA COLLEGE	REDDING CA	04175	Associates in Nursing	05/01/1997

OTHER STATES OF LICENSURE/CERTIFICATION

LIC/CERT NO	STATE	LIC/CERT TYPE	STATUS	LIC/CERT DATE	ORIG STATE
538245	CA	REGISTERED NURSE	Active: Good Standing		N

MOST RECENT APPLICATION INFORMATION

Year: 2005
Employment Status:
Type of Nursing Position: Staff/General Duty Nurse/Team Leader/Charge Nurse
Major Clinical or Teaching Area in Nursing: Special Care (e.g. OR, ER, ICU, CCU)

BEFORE THE ARIZONA STATE BOARD OF NURSING

IN THE MATTER OF REGISTERED NURSE LICENSE NO.: RN109600 ISSUED TO: CHARLES ALAN BENNETT RESPONDENT	)	**CONSENT AGREEMENT AND ORDER NO. 0808033**

CONSENT AGREEMENT

A complaint charging CHARLES ALAN BENNETT (hereinafter "Respondent") with violation of the Nurse Practice Act has been received by the Arizona State Board of Nursing (hereinafter "Board"). In the interest of a prompt and speedy settlement of the above-captioned matter, consistent with the public interest, statutory requirements and the responsibilities of the Board, and pursuant to A.R.S. § 41-1092.07 (F)(5), the undersigned parties enter into this Consent Agreement as a final disposition of this matter:

Based on the evidence before it, the Board makes the following Findings of Fact and Conclusions of Law:

FINDINGS OF FACT

1. Respondent holds Board issued registered nurse license no. RN109600.

2. From on or about July 1, 2007 to on or about August 20, 2007, Respondent was employed as a Registered Nurse (RN) at Paradise Valley Hospital, in Phoenix, Arizona. Respondent was terminated and deemed ineligible for rehire when he failed to work an assigned shift on August 21, 2007.

3. From on or about June 1, 2007 to on or about September 11, 2008, Respondent was employed as an RN with Health Temp registry.

4. On or about August 4, 2008, the first complaint was filed against Respondent's license by Dee Patrick, Director, Health Temp. The complaint alleged, on or about July 31, 2008, while on assignment at Maryvale Hospital in Phoenix, Arizona, Respondent administered intravenous (IV) potassium and Diprovan/propofol without an IV pump; resulting in patients receiving a medication bolus. Maryvale Hospital designated Respondent a "Do Not Return" for unsatisfactory performance and failure to adhere to hospital policies and procedures. Respondent was terminated

5. From on or about September 9, 2008 to on or about November 19, 2008, Respondent was employed with Bridge Staffing, a registry.

6. On or about November 21, 2008, a second complaint was filed against Respondent's license by Banner Boswell Medical Center (BBMC). The complaint alleged, on or about November 19, 2008, while assigned to BBMC, Respondent was designated a "do not return" for suspected diversion after a footprint seen on the toilet seat of the employee bathroom led to the discovery of multiple medications stashed in a ceiling compartment above the toilet. An investigation by BBMC revealed the medications found in the ceiling compartment corresponded with Respondent's Pyxis transaction and removal, including:

a. Benadryl/diphenhydramine 50 mg – (3 vials)

b. Percocet/oxycodone 5/325 mg – (2 tablets)

c. Zofran/ondansetron 4 mg – (3 vials)

d. Lopressor/metoprolol 25 mg – (3 vials)

e. Dilaudid/hydromorphone 1 mg – (3 vials)

f. Valium/diazepam 10 mg (1 vial)

g. Toradal/ketorolac 30 mg (2 vials)BBMC noted that Kenalog/tramcinolone acetonide 40 mg (1 vial) was also removed and found in the ceiling compartment, but did not correspond with Respondent's Pyxis transactions.

7. On November 19, 2008, Respondent completed a "for cause" urine drug screen and tested negative for all substances.

8. On or about November 26, 2008, Guy Trahan, RN, Interim Director, Emergency Department at BBMC told Board staff that Respondent was assigned to BBMC by Bridge Staffing from on or about September 9, 2008 to November 19, 2008. Trahan reported that during Respondent's BBMC assignment:

a. Respondent had attendance issues;

b. Respondent was chronically late;

c. Respondent used his personal cell telephone in different areas of the hospital; and

d. Respondent left the ED temporarily without notifying other staff approximately three (3) to five (5) different times; ED staff were unaware of his whereabouts;

e. Respondent's registry assignment at BBMC was terminated on or about November 19, 2008, due to the "evidence" found.

9. On or about September 22, 2008, Respondent was informed by First Class Mail of the first complaint against his license, and requested to complete and return the Board's Investigative Questionnaire. Respondent failed to complete and return the questionnaire.

10. On or about November 26, 2008, Board staff attempted to contact Respondent at his home and cell telephone numbers of record. The numbers were either not working or

disconnected.. A subsequent email to Respondent's email address of record was returned to the Board as undeliverable.

11. On or about December 2, 2008, Respondent was informed by First Class Mail of the second complaint against his license, and requested to complete and return the Board's Investigative Questionnaire. Respondent failed to complete and return the questionnaire.

12. On or about December 15, 2008, Respondent was informed for a second time by First Class Mail of the second complaint against his license, and requested to complete and return the Board's Investigative Questionnaires. The notification letter was sent to a new address obtained from Respondent's employment files. On or about December 16, 2008, a second email was sent to Respondent at a new email address obtained from Respondent's employment files. On December 17, 2008, Respondent called investigator.

13. On December 18, 2008, Respondent submitted his written response to the first complaint. Respondent denied that he failed to use an IV pump to administer intravenous potassium and Diprovan/propofol to patients in the emergency room at Maryvale Hospital. Respondent denied that either patient received a medication bolus. . Respondent admitted there was Diprovan/propofol medication waste due to his initial use of the wrong type of IV tubing (non-vented versus vented IV tubing). Respondent did not address the second complaint of alleged narcotics diversion within his written response.

14. From on or about February 17, 2009 to March 2, 2009, Respondent failed to respond to three separate requests (by telephone and email) for an interview with Board staff.

15. On or about March 18, 2009, in an interview with Board staff, Respondent reported he was newly employed as a nightshift RN in the Emergency Department (ED) at St.

Joseph's Hospital and Medical Center (SJHMC). Respondent stated his employment at SJHMC was going very well and that he had already been nominated for employee of the month.

16. On or about March 18, 2009, in an interview with Board staff and in response to the first complaint stemming from alleged incidents at Maryvale Hospital, Respondent denied that either patient received an IV bolus of medication. However, Respondent admitted that he wasted approximately 50 ml of Diprovan/propofol when he primed and incorrectly used two sets of non-vented IV tubing, instead of vented IV tubing to start a patient's Diprovan IV drip. Contrary to his written statement, Respondent reported that he received a patient who had a potassium IV drip infusing at a "To Keep Open (TKO) rate." but failed to place the potassium on an IV pump. Respondent further admitted that standard of care requires intravenous potassium to be infused with an IV pump.

17. In response to the second complaint, Respondent denied that he had ever diverted any drugs from BBMC, for himself or others and denied present or past substance abuse. Respondent asserted that he could not have diverted the medications found in the ceiling compartment of the employee bathroom at BBMC because he is 5 feet 4 inches tall. Respondent stated his height restriction would prevent him from accessing the ceiling compartment, even if he were standing on top of the toilet seat. Respondent stated he believed that the medications found in the ceiling compartment were diverted by another registry employee named "Adam" [Kuzmiak, RN]. Respondent stated Kuzmiak reported he did not have a working Pyxis password. Respondent stated he accessed the Pyxis, "signed out" medications and gave them to Kuzmiak for patient administration.

18. On or about March 18, 2009, Respondent underwent a random urine drug screen at Sonora Quest Laboratories and tested negative for all substances.

19. From on or about January 12, 2009 to on or about March 26, 2009, Respondent was employed at St. Joseph's Hospital and Medical Center (SJHMC).

20. On or about March 26, 2009, a third complaint against Respondent's license was filed by St. Joseph's Hospital and Medical Center (SJHMC). Respondent was notified in a telephone call from Board staff that a third complaint against his license had been received. According to the complaint, on or about March 20, 2009, co-workers working in the Emergency Department (ED) complained that Respondent frequently asked them to "witness" and sign off for narcotic wastes without visually observing the waste. SJHMC reported that the audit revealed:

a. Respondent used significantly more narcotics than any other ED nurse;

b. Respondent made multiple errors in eighty-nine (89) out of ninety (90) charts reviewed;

c. Respondent pulled narcotics for patients not assigned to him;

d. Respondent pulled narcotics for patients who were already discharged from the ED;

e. Respondent failed to properly waste narcotics not given and /or have narcotic waste witnessed by other staff nurses; and

f. Respondent failed to properly document narcotics administration.

21. On or about March 26, 2009, the Board voted to issue and Interim Order for a substance abuse evaluation, to be completed by Respondent within sixty days. Respondent failed to comply with the Interim Order.

22. On or about April 30, 2009, Respondent was informed by First Class and Certified Mail of the third complaint against his license, and requested to complete and return the Board's Investigative Questionnaire.

23. On or about April 30, 2009, Respondent notified Board staff that he had applied for employment with Medical Solutions, a registry. Respondent reported he was hired by Medical Solutions for a travel assignment in California, but the offer was rescinded after the company discovered Respondent's license was under investigation by the Arizona State Board of Nursing (AZBN).

24. On or about April 30, 2009, a Nurse Recruiter from Medical Solutions told Board staff that Respondent had applied to work for Medical Solutions under his active California RN license. Respondent failed to disclose to the company that he was licensed as an RN in Arizona and under investigation by the AZBN.

25. On or about May 4, 2009, the Board received an anonymous complaint alleging that Respondent had taken home narcotics, Toradol/ketorolac and IV solutions and administered the drugs and IV solutions to family members.

26. On or about May 6, 2009, in an interview with Board staff:

a. Respondent denied diversion of narcotics at SJHMC and attributed his errors to poor documentation;

b. Respondent reported to Board staff that his wife was very sick and had recently been diagnosed with Cancer and Cushing's Syndrome. Respondent said that his wife was very distressed about her diagnosis because her mother (Respondent's mother-in-law) had recently died of cancer;

c. Respondent admitted that from on or about February 2009 to March 2009, while employed at SJHMC, he took Bereavement Leave for the death of his mother-in-law. Respondent further acknowledged that on or about March 2, 2009, in an email to Laura Peters, RN, ED Manager, SJHMC, he requested short notice Bereavement Leave for Friday, March 6, 2009, in order to meet with a lawyer to settle his mother-in-law's estate;

d. Respondent then admitted to Board staff that his mother-in-law, Joanne Buelow, was alive and not dead. Respondent further admitted that he lied to his employer, SJHMC, when he falsified his request for Bereavement Leave due to the "death" of Buelow;

e. Respondent admitted that he listed the names of family members as employment references on an application for employment at SJHMC. Respondent also admitted that he listed his wife, Shonda Owen, and mother-in-law, Joanne Buelow, as Charge RNs/former co-workers. Respondent initially reported to Board staff that his wife, Owen, was an RN, but later admitted that he lied; as neither his wife nor mother-in-law was a nurse. Respondent further admitted that his wife and mother-in-law represented themselves as nurses to SJHMC employees who called for employment references;

f. Respondent admitted that he had, on prior occasions, administered IV fluids to his wife (Owen), mother-in-law (Buelow) and fourteen year old step-daughter ("Samantha"), without valid physicians' orders.

Respondent stated he obtained the IV supplies from on "old" Emergency Medical Technician (EMT) kit that he still had at home;

g. Respondent denied that he had diverted medications, narcotics or medical supplies for his personal or family's use. Respondent further denied that he had ever administered non-prescription medications or narcotics to himself or family members.

27. On or about June 8, 2009, Respondent was scheduled to complete a Board-ordered psychological evaluation with Phillip Lett, Ph.D., at the offices of Professional Psychology Associates, in Phoenix, Arizona. Respondent also failed to appear or cancel his scheduled appointment.

CONCLUSIONS OF LAW

Pursuant to A.R.S. §§ 32-1606, 32-1663, and 32-1664, the Board has subject matter and personal jurisdiction in this matter.

The conduct and circumstances described in the Findings of Fact constitute violations of A.R.S. §§ 32-1663 (D) as defined in 32-1601(16) (d), (g), (h), (i) and (j); and A.A.C. R4-19-403 (B) (1), (7), (8)(b), (9), (12), (16), (18), (26), (27) and (31) (adopted effective November 12, 2005) and A.A.C. R4-19-403 (1), (7), (8)(b), (9), (12), (16), (18), (26), (27) and (31) (adopted effective February 2, 2009)

The conduct and circumstances described in the Findings of Fact constitute sufficient cause pursuant to A.R.S. § 32-1664(N) to revoke, suspend or take other disciplinary action against the license of Respondent to practice as a registered nurse in the State of Arizona.

Respondent admits the Board's Findings of Fact and Conclusions of Law.

In lieu of a formal hearing on these issues, Respondent agrees to issuance of the attached Order and waives all rights to a hearing, rehearing, appeal or judicial review relating to the Order except in the limited circumstance(s) specified in Paragraph 9 of Terms of Suspension. Respondent understands that all investigative materials prepared or received by the Board concerning these violations and all notices and pleadings relating thereto may be retained in the Board's file concerning this matter.

Respondent understands that those admissions are conclusive evidence of a prior violation of the Nurse Practice Act and may be used for purposes of determining sanctions in any future disciplinary matter.

Respondent understands the right to consult legal counsel prior to entering into this Consent Agreement and such consultation has either been obtained or is waived.

Respondent understands that this Consent Agreement is effective upon its acceptance by the Board and by Respondent as evidenced by the respective signatures thereto. Respondent's signature obtained via facsimile shall have the same effect as an original signature. Once signed by Respondent, the Agreement cannot be withdrawn without the Board's approval or by stipulation between Respondent and the Board's designee.

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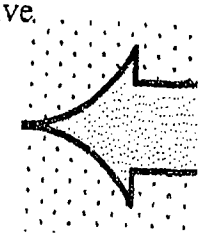
The effective date of this Order is the date the Consent Agreement is signed by the Board and by Respondent. If the Consent Agreement is signed on different dates, the later date is the effective date.



Respondent

Dated: 6/18/09

SEAL

ARIZONA STATE BOARD OF NURSING

Joey Ridenour RN MN FAAN

Joey Ridenour, R.N., M.N., F.A.A.N.
Executive Director

Dated: June 4, 2009

SCHETTLER/RN109600/BENNETT

ORDER

In view of the above Findings of Fact, Conclusions of Law and the consent of Respondent, the Board hereby issues the following Order:

A. Respondent's consent to the terms and conditions of the Order and waiver of public hearing are accepted.

B. Respondent's license is placed on suspension for an indefinite period of time pending completion of a psychological evaluation by a Board-approved evaluator who is at minimum Ph.D. prepared, and the successful completion of any treatment recommendations resulting from the evaluation. Following the completion of the evaluation and treatment

resulting from the evaluation, the Board shall determine the continued status of Respondent's nursing license.

C. This Order becomes effective upon the Board and the Respondent's acceptance of the Consent Agreement. The effective date is the date the Consent Agreement is signed by the Board and the Respondent. If the Consent Agreement is signed on different dates, the later date is the effective date.

D. If Respondent is noncompliant with any of the terms of the Order, Respondent's noncompliance shall be reviewed by the Board for consideration of possible further discipline on Respondent's nursing license.

E. If Respondent is convicted of a felony, Respondent's license shall be automatically revoked for a period of five years. Respondent waives any and all rights to a hearing, rehearing or judicial review of any revocation imposed pursuant to this paragraph.

F. If Respondent fails to renew his license and it remains expired for two or more years, Respondent's license will automatically be revoked. Respondent waives the right to hearing, rehearing, appeal, or judicial review relating to this Order except in the limited circumstances specified in Paragraph 9 of the Order.

G. The suspension is subject to the following terms and conditions:

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TERMS OF SUSPENSION

1. Surrender of License

Respondent agrees to immediately surrender Respondent's license to the Board and will not practice nursing for an indefinite period of time pending completion of a psychological evaluation.

2. Psychological Evaluation

Prior to the termination of Suspension Respondent shall make an appointment to undergo a comprehensive psychological evaluation with psychometric testing by a Board-approved psychologist, to be completed within one year of the effective date of the Order. **If Respondent fails to complete the evaluation as required by this paragraph within one year from the effective date of this Order, Respondent's license shall be automatically revoked. Respondent waives the right to appeal any revocation imposed as a result of his failure to undergo the required evaluation.** Respondent shall execute the appropriate release of information form(s) to allow the evaluator to communicate information to the Board or its designee. Respondent consents to the Board providing the evaluator with any documents deemed pertinent by the Board of its designee, which may include the Board's investigative report. Prior to the evaluation, Respondent shall furnish a copy of this Consent Agreement and Order to include Findings of Fact, Conclusions of Law, and Order to the evaluator who shall verify receipt of the Consent Agreement and Order to include Findings of Fact in a written report on letterhead to the Board. Respondent shall direct the evaluator to provide a report to the Board summarizing the evaluation within thirty days after the evaluation is completed. The report shall include a history and physical, relevant laboratory data if appropriate, psychological testing if appropriate,

recommendations for treatment, if any, and an assessment as to Respondent's ability to function safely in nursing.

If it is recommended that Respondent undergo medical treatment and/or psychological therapy or counseling, Respondent shall, within seven days of notification of the recommendation(s), provide to the Board or its designee for prior approval, the name and qualifications of treatment professional(s) with appropriate level of expertise of Respondent's choice. Upon approval of the treatment professional(s), Respondent shall provide a copy of the entire consent agreement which the treatment professional(s) shall verify in writing on letterhead in their first report to the Board. Respondent shall undergo and continue treatment until the treatment professional(s) determines and reports to the Board in writing and on letterhead, that treatment is no longer considered necessary. Respondent shall have the treatment professional(s) provide written reports to the Board monthly. The Board reserves the right to amend this Order based on the evaluation results or the treatment professional's recommendations.

3. Obey all Laws

Respondent shall obey all laws/rules governing the practice of nursing in this state and obey all federal, state and local criminal laws. Respondent shall report to the Board, within 10 days, any misdemeanor or felony arrest or conviction.

4. Interview with the Board or its Designee

Respondent shall appear in person for interviews with the Board or its designee upon request at various intervals and with reasonable notice.

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5. Change of Employment/Personal Address/Telephone Number

Respondent shall notify the Board, in writing, within 7 days of any change in nursing employment, personal address or telephone number. Changes in nursing employment include the acceptance, resignation or termination or employment.

6. Renewal of License

In the event the license is scheduled to expire while this Order is in effect, Respondent shall apply for renewal of the license and pay the applicable fee.

7. Release of Information Forms

Respondent shall sign all release of information forms as required by the Board or its designee and return them to the Board within 10 days of the Board's written request. Failure to provide for the release of information, as required by this paragraph constitutes non-compliance with this Order.

8. Costs

Respondent shall bear all costs of complying with this Order.

9. Violation of Suspension

If Respondent violates this Order in any respect other than as identified in TERM 2 (Psychological Evaluation) the Board, after giving Respondent notice and the opportunity to be heard, may revoke Respondent's license or take other disciplinary action. If a complaint is filed against Respondent during suspension, the Board shall have continuing jurisdiction until the matter is final, and the period of suspension shall be extended until the matter is final.

10. Voluntary Surrender of License

Respondent may, at any time this Order is in effect, voluntarily request surrender of his license.

11. Completion of Suspension

Respondent is not eligible for early termination of this Order. Following the successful completion of the evaluation and treatment resulting from the evaluation, Respondent shall request formal review by the Board. After formal review by the Board, the Board will determine the status of the nursing license, which may include a period of continued suspension and/or monitored practice.

SEAL

ARIZONA STATE BOARD OF NURSING

Joey Ridenour RN MN FAAN

Joey Ridenour, R.N., M.N., F.A.A.N.
Executive Director

Dated: June 4, 2009

JR/as:ts

COPY mailed this 11th day of June, 2009, by First Class Mail, to:

Charles Alan Bennett
12622 W Missouri Ct
Litchfield Park, AZ 85340

AND

Charles Alan Bennett
16800 W Mesquite Dr
Goodyear, AZ 85338

By: Trina Smith
Legal Secretary